# OAKENHURST MEDICAL PRACTICE

COMPLAINT FORM

Patient Full Name:

Date of Birth:

Address:

Complaint Details: (Please give full details of the complaint below including dates, times, locations and names of any practice staff (if known). Continue a separate page if required.

|  |
| --- |
|  |

SIGNED…………………………………. PRINT NAME…………………………

DATE…………………………………….

# OAKENHURST MEDICAL PRACTICE

PATIENT THIRD-PARTY CONSENT

If you are complaining on behalf of a patient or your complaint or enquiry involves the medical care of a patient, then the consent of the patient will be required. Please obtain the patient’s signed consent below.

**SECTION ONE: PATIENT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Title |  |
| Forename |  |

|  |
| --- |
| Address |
|   |

 |  |
| Date of Birth |  |
| Telephone no. |  | Postcode |  |

**SECTION TWO: THIRD PARTY DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Title |  |
| Forename |  |

|  |
| --- |
| Address |
|   |

 |  |
| Date of birth |  |
| Telephone No. |  | Postcode |  |

**SECTION THREE: DECLARATION**

I hereby authorise the individual detailed in Section 2 to act on my behalf in making this complaint and to receive such information as may be considered relevant to the complaint. I understand that any information given about me is limited to that which is relevant to the subsequent investigation of the complaint and may only be disclosed to those people who have consented to act on my behalf.

This authority is for an: *(delete as appropriate)*

* Indefinite period
* For a limited period only

Where a limited period applies, this authority is valid until ………. /………. /………. *(Insert date).*

Print Name: (Patient only)

Signed: (Patient only)

Date: